First Annual Report

Dangerous Mentally Ill Offender Legislation
Chapter 214, Laws of 1999 (SSB 5011)

January 2001

This is the first Annual Report on the implementation of the Dangerous Mentally Ill Offender (DMIO) legislation, Chapter 214, Laws of 1999 (SSB 5011). It is intended to provide to interested persons a summary of the development of the implementation process and the current implementation status. The Departments of Social and Health Services (DSHS) and Corrections (DOC) began planning shortly after the signing of the act. Formal implementation activities, with multiple stakeholders, began in September 1999. This report includes information as of December 31, 2000.

Background

Legislation

The Dangerous Mentally Ill Offender legislation was enacted into law during the 1999 session of the Washington State Legislature. It is intended to help provide improved public safety and additional mental health treatment for dangerous mentally ill and chemically dependent mentally ill offenders. The law became effective March 15, 2000, with the following provisions:

- Requires the identification of dangerous mentally ill offenders being released from DOC facilities into the community;
- Requires DSHS and DOC to enter into a written agreement, or draft rules, to expedite financial and medical eligibility determination for this type of offender;
- Requires pre-release planning, including possible civil commitment evaluation, by inter-agency teams. The teams must include representatives from DSHS, DOC, the Regional Support Networks (RSN), and mental health providers;
- Provides additional funds for services to these offenders at approximately $10,000 per person annually for up to five years; and
- Requires an impact study by the Washington State Institute for Public Policy and Washington Institute for Mental Illness Research and Training.

Implementation Planning

DSHS and DOC used a quality management process to develop implementation strategies. A draft charter was developed and stakeholders were invited to participate in a process to develop the implementation plans. The initial meeting of the inter-

system group, named the DMIO Implementation Council, was held in September 1999. Participants included representatives from DSHS, DOC, the RSNs, Washington Community Mental Health Council, National Alliance for the Mentally Ill (NAMI-WA), Washington Advocates for the Mentally Ill, Washington Association of County Designated Mental Health Professionals, and mental health consumers.

The Council reviewed the existing systems and other service delivery innovations to develop a DMIO implementation plan consistent with statutory requirements. A summary of the plan can be found in *Appendix A*. Key components of the implementation plan include:

- Identification, by DOC, of a pool of potential candidates;
- Selection as a DMIO program participant by the Statewide Multi-System Review Committee;
- Selection timed to permit three (3) months of active engagement with the program participant prior to release from prison;
- Community service/care planning by multi-system teams (mental health, substance abuse, corrections, developmental disabilities, law enforcement, and others);
- Expedited financial and medical eligibility determination; and
- Coordinated implementation of individualized service/care plans.

Implementation – April 2000 through December 2000

The Statewide Multi-system Review Committee meets monthly. It met for the first time in March 2000 and began to select DMIO program participants the following month. Committee membership includes representatives from DOC, three (3) divisions of DSHS (Mental Health, Alcohol and Substance Abuse, and Developmental Disabilities), the RSNs, mental health providers, Washington Association of County Designated Mental Health Professionals (CDMHPs), and law enforcement. The Committee's prime responsibility is to select persons for DMIO program participation. A summary of the Committee's other responsibilities, including a current draft of formal committee processes and DMIO program participant selection criteria, can be found in *Appendix B.*

The selection process of potential candidates within DOC utilizes the electronic database, which contains both demographic and clinical information. A computer-generated list of names based on a number of offender characteristics is reviewed by the DMIO program staff and screened further for the selection of candidates. Following that screening process, the DOC institution is contacted for the purpose of obtaining additional and more detailed information.

Once that information is gathered, and the likelihood of the presence of a major mental disorder appears to be confirmed, a full packet of information about that offender is requested and sent to the DMIO program staff in DOC headquarters. Additionally, mental health staff at the DOC institutions and RSN staff may submit referrals on offenders who may not appear on the database, but are deemed appropriate for review. All information packets are screened and edited by the DMIO program staff and then presented to the Statewide Review Committee for final determination of DMIO program eligibility.

As of December 31, 2000, a total of thirty-six (36) individuals had been selected to participate in the DMIO program, and thirteen (13) participants have been released from correctional facilities. The first DMIO program participant was released to Pierce County on September 6, 2000. Three (3) program participants have a developmental disability and are also clients of the DSHS Division of Developmental Disabilities.

The table below shows the number of persons reviewed and selected during the 2000 calendar year. Additional information on the persons selected can be found in *Appendix C*.

Program Participant Selection 2000

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Selected	1	3	5	2	4	7	5	5	4	36
Not Selected	1	4	7	5	0	0	0	0	0	17[1]
Deferred	5	5	0	1	3	3	2	0	1	20[2]
Total Reviewed	7	12	12	9	7[3]	10[4]	7	5	5	53

Three statewide DMIO program manager positions – one each in DOC, the DSHS Mental Health Division, and the DSHS Division of Alcohol and Substance Abuse (DASA) - plus a full time DOC risk management specialist position were established and filled by August 2000. These staff have taken the lead in implementing the DMIO program across systems statewide. Working as a team, they have provided guidance, direction and training throughout the state to the RSNs and available service providers regarding the DMIO program and implementation of the local multi-system care planning teams.

[1] Of the offenders not selected, ten (10) did not meet the criteria of mental disorder; five (5) did not meet the criteria of dangerousness; one (1) was facing an additional nineteen years of incarceration on a federal detainer for weapons violations; and one (1) did not meet the release date criteria.

[2] Most of the deferred offenders were later reviewed again and are included in subsequent months.

[3] One additional offender, who was previously not selected due to lack of a mental disorder, was reviewed again at the request of the DOC institution staff. The committee's prior decision was upheld.

[4] One additional offender, who was earlier determined DMIO eligible, was reviewed again at the RSN's request. The committee's prior decision was upheld.

In accordance with RCW 72.09.370, an interagency agreement was adopted between DSHS and DOC to assure a joint working relationship to expedite financial and medical eligibility determinations for the DMIO program participants. Subsequently, an interagency training session involving the Community Services Division (DSHS Economic Services Administration) and DOC personnel was conducted in December 2000 to train staff to effectively and efficiently implement this agreement.

Community Service/Care Planning Model

Community care planning is a collaborative process that includes representatives from mental health, corrections, alcohol and drug treatment, developmental disabilities, and law enforcement working together to insure that program participants are provided mental health, substance abuse treatment, and other needed services in the community.

Once a DMIO program participant has been identified and designated to transition through a specific community, the appropriate RSN and County Alcohol and Drug Coordinator are notified. Background information is sent to them for their review. The RSN and County Alcohol and Drug Coordinator then select mental health and chemical dependency providers. If the program participant has a developmental disability and is eligible for DDD services, DDD is notified.

Each program participant is assigned two (2) DOC Risk Management Specialists (RMS) at least three (3) months prior to release. One is the institution RMS and the other is the field RMS. If the offender has community supervision upon release, a Community Corrections Officer (CCO) is also assigned to the offender.

A DMIO program participant is, by DOC policy, determined to be risk management level "A" and would be included in those specified supervision requirements under the Offender Accountability Act (OAA). If DOC has post release community placement and supervision over a program participant, his or her supervision in the community includes, at a minimum, weekly contact with a member of the DOC Risk Management team, weekly documentation and verification of activities that have occurred and the offender's compliance with the conditions of supervision. The DOC staff are an integral part of the local planning team and work closely with the service providers and other team members to ensure the best possible transition and care plan.

An organizational meeting of system and agency representatives is held early in the planning process to determine specific roles and responsibilities. This would include individuals from the designated RSN, appropriate DSHS division liaisons, and DOC risk management staff. Whenever possible, mental health and chemical dependency professionals arrange to visit the offender together, to promote their appearance as a team and to lessen logistical arrangements that need to be set up at the correctional institutions.

The initial planning meeting is very important, as this is when key players are identified to work with the offender. As early as possible, case managers are selected and matched with each DMIO program participant. Others in attendance may include community mental health center staff, chemical dependency providers, RSN administrators, family members, CDMHPs, community corrections officers (CCOs), and law enforcement. When the program participant is also a DDD client, the DDD Clinical Practices Manager and DDD case resource manager are involved.

Once the team is formed, the planning begins. Case managers, chemical dependency providers, CCOs, and CDMHPs visit the correctional facility and discuss the DMIO program with the participant. This should occur between three to six months prior to release in order to develop a preliminary transition plan.

To date, pre-release planning meetings have been held both at the correctional facilities and in the community. These meetings should include the offender whenever possible as well as the case manager, correctional facility staff, and identified service providers. This is to establish rapport with the program participant and determine if any further assessments or evaluations need to be scheduled and completed prior to release (e.g., psychiatric/psychological, chemical dependency assessment, psychosexual evaluation). Family members and significant others may also participate in the pre-release planning process.

There is no limit to the number of meetings that may be required to finalize the transition plan. However, the team must work under the umbrella of an accepted release plan from DOC, an expected release date (ERD), and a maximum release date (MRD). Prior to the program participant's release, the team is also expected to develop a detailed plan for the first 48 hours post-release.

The team uses a standard Multi-System Care Plan form to document decisions and plan specifics. First, the team thoroughly reviews all available assessments and/or evaluations and the person's treatment history. Second, the team identifies any gaps in information and decides how to obtain that information. Third, the team begins to discuss the various plan components and develop strategies and actions. Key elements of the transition plan are:

- Release issues (community notification, victim/witness, etc.);

- Relapse prevention strategies (individual skills and strengths that contribute to the prevention of relapse, and problematic environments and behaviors that trigger relapse);

- Pre-release engagement services (assessments to determine treatment needs in the community, strategies for motivational engagement to enhance treatment compliance);

- Service needs in the community
  - Housing
  - Basic necessities (food, clothing, personal items, etc.)
  - Activities of daily living
  - Safety and crisis plans
  - Relationships with family and/or significant others
  - Medical/Therapeutic
  - Substance Abuse
  - Cultural issues
  - Educational/vocational
  - Employment
  - Social/recreational
  - Legal;

- Service Providers (list of specific providers identified to work with the program participant with names, phone numbers, addresses);

- Financial resources/funding (e.g., Medicaid, Medicare, Supplemental Security Income (SSI), General Assistance –Unemployed (GAU), DMIO funds, individual assets, etc.); and

- Community corrections information (type of jurisdiction, court obligations for supervision, plan for collaboration with case managing agency, proposed alternatives to return to prison for violations, etc.).

DMIO Program Sample Transition Plan

The following transition plan is an example of a typical plan. However, each DMIO program participant has different needs and priorities that will be individually reviewed and addressed. It should be noted that the plan below has a shorter planning time than what would normally be expected.

Program Participant: John Jones (name and other identifiers have been changed or omitted).

The initial pre-release planning meeting was held 8/15/00 with twelve representatives from mental health, chemical dependency, and DOC. Various services issues and strategies were discussed regarding how to best serve and supervise Mr. Jones in the community. Housing is clearly the most difficult issue to address. MW, a sexual deviance specialist, was in the process of conducting an evaluation of Mr. Jones' risk issues and treatment needs upon release. He conducted an initial interview on 8/7/00 and will follow up with additional interviews and records prior to issuing a report.

A Pierce County RSN representative and mental health case manager met with Mr. Jones on 8/23/00 to discuss his treatment and housing issues. The CCO also meet with

Mr. Jones at this time. We want Mr. Jones to know that this is a coordinated system of care.

Pre-release Engagement Services
An in-person meeting with John Jones was held on 8/23/00. Participants included: John Jones; JJ, Pierce Co. RSN; AJ, Risk Management Specialist, DOC; AC, Case manager, Comprehensive Mental Health; AB, Community Corrections Officer, DOC; TF, DASA; JS, MHD; KS, Reflections CD provider; and members of the McNeil Island Correctional Center treatment team, Dr. K, Dr. M and MF.

They discussed with Mr. Jones his perspective about his release, expectations for assistance, community supervision, and the roles that each team member was taking in helping him be successful in the community. As expected, he tested some boundaries regarding supervision, community notification, and treatment participation. The question of housing is still the largest issue to be resolved. While he is concerned about this, Mr. Jones indicated the capacity and willingness to stay in a shelter temporarily. AC assured him that his housing needs would be met, but it was made clear that his housing options were limited.

We did review in detail the day of his release and what to expect. The CCO and Risk Management Specialist will meet Mr. Jones at the dock and escort him to meet with his case manager to help him get settled. AC and KS met with Mr. Jones to get further acquainted in order to conduct a chemical dependency assessment. The preliminary results indicate Mr. Jones was/is marijuana dependent and in need of treatment. Statements made by Mr. Jones indicate considerable ambivalence about receiving chemical dependency treatment.

Release Issues
Community notification required: Level III Sex Offender. Contact Sheriff's Department regarding community notification steps.

Relapse Prevention
AC at Comprehensive Mental Health is seeing Mr. Jones twice weekly (T/F). AC is doing case management outreach to Mr. Jones' apartment and also meets with him individually at the mental health center. AC reports that Mr. Jones' mental status is stable and he is complying with treatment. Medication appointment is scheduled for 9/25/00. Mr. Jones was released with a 30-day supply of medication that is being monitored by the mental health center. Mr. Jones' CCO sees him twice weekly on Tuesdays and Thursdays.

Chemical Dependency Treatment
Reflections Recovery and Learning Center, a chemical dependency provider, recommended group and individual counseling. Mr. Jones has so far complied with treatment and is attending group three days per week (M/W/F) and individual counseling once per week.

Special Risk Plan (e.g., sexual deviancy, assault, dangerousness)
Mr. Jones will be contacting his assigned CCO twice a week or more often as needed. AB will postpone Moral Recognition Therapy and Relapse Prevention requirements in favor of using these as graduated sanctions should Mr. Jones have problems complying with community supervision.
MW completed an assessment and did not recommend sexual deviancy treatment at this time as he felt Mr. Jones is not amenable. He also indicated he believed Mr. Jones would do well in the community as long as he has case management and drug treatment with DOC supervision.

Day of Release Plan
Transportation: AB and AJ met Mr. Jones when he was released on 9/6/00,reviewed his conditions of release with him, and then took him to meet with AC, his case manager.
Housing: AJ (DOC) secured housing with moving costs covered by Pierce County RSN.
Mental Health Provider: Comprehensive MH Center, South 13th Street, Tacoma, WA.
Chemical Dependency Treatment Provider: Reflections Recovery and Learning Center, Gravelly Lake Drive SW, Lakewood, WA.
DOC contacts: AB, Community Correction Officer and AJ, Risk Management Specialist

Mental Health Crisis Prevention Plan
Mr. Jones' first line of defense is to call his mental health case manager, AC, at 333-3333. If AC is not available, he can be paged by reception at CMHC. Back-up coverage will be provided by JS (333-3334). The Crisis Triage Center is available 24 hours a day/seven days a week if Mr. Jones has a psychiatric emergency that requires supervised care. The phone number is 333-3344 and the address is 721 South Fawcett, Tacoma, WA.

Follow Up

The local planning teams are expected to follow the program participant for at least thirty days after his or her release from the correctional facility. Beyond thirty days, the post-release involvement of each team varies according to the needs of each program participant.

The RSNs are responsible to maintain, in addition to other routine documentation, monthly written records of ongoing treatment and supports not generally covered under the Prepaid Health Plan (PHP) and purchased with funds provided under the DMIO legislation. They are also required to submit to the MHD an annual report, which must identify the total number of persons served and the type of support services provided to each DMIO program participant not generally covered under the PHP.

Accomplishments and Progress Made

As of the end of December 2000, thirteen participants have been released from the correctional facility to the community. The following is a brief report of the status of each released person.

Clark County RSN: (2 Participants)

- One person is actively involved in mental health treatment, keeping weekly appointments with his case manager and is medication compliant. He also is involved in chemically dependency treatment and has not had any relapses. The county used some of the DMIO money to enroll this participant in two classes at Clark College.
- The second participant moved, with DOC permission, to the state of Oregon.

King County RSN: (5 Participants)

- One participant was civilly committed to Western State Hospital and is currently on a 180 day-court commitment. A King County liaison has contact on a regular basis for release planning.
- Another participant is having a difficult time with compliance in spite of the RSN's many attempts to engage her in services. She lives with her family and has been AWOL three times. She refuses to utilize any chemical dependency services and has only kept one mental health appointment for medications. There is currently a warrant out for her arrest for violations of her community protection orders.
- A third participant is doing very well. He lives in a residential facility in the community and receives daily supervision. He has kept all his appointments with his mental health and chemical dependency counselors. He is medication compliant and attends AA on a weekly basis.
- A fourth person lives independently in a motel and with his case manager is looking for an apartment. He is seen on a daily basis by case manager and reports daily to his community correction officer. He initially refused his antipsychotic medications however, is currently medication compliant. He has been referred for chemical dependency evaluation and treatment.
- The transition of the fifth person exemplified many of the challenges associated with program. The community planning process began with an expectation that the person would be released in December 2000. Unknown to planners, the participant's own release had been approved and his release date was changed to September 14, 2000. By the time of his release he had decompensated due to medication non-compliance, was expressing strong denial about his mental illness and the placement he had arranged proved to be inadequate for his needs. Additionally there was delay in having a community corrections officer assigned and involved in case planning. All these factors served to undermine the transition process. Shortly after his arrival in Seattle, the person began to violate his supervision plan and it became necessary to arrest him and return him to DOC custody. While in custody he was put on involuntary psychiatric medications and his psychiatric condition stabilized. He actively participated in the second transition planning process and is currently in a stable living situation and is participating in mental health treatment.

North Central Washington RSN: (1 Participant)

- The one participant in this RSN resides with a friend who supports his community transition and takes him to all his appointments. He attends weekly mental health sessions and is medication compliant. He was initially seen weekly and is now being two times a month. The RSN is using some of the funds to buy clothes, which increases compliance as the participant "likes to look good" He receives chemical dependency services three days a week and goes to AA on a weekly basis also.

North Sound RSN: (3 Participants)

- One participant was admitted to Western State Hospital on a civil commitment and remains there on a 90 day court commitment. A RSN liaison has contact on a regular basis for release planning.
- The second person lives in community with his family. Collaboration between DOC institution staff and community service staff resulted in his starting on antibuse prior to his release. He sees both his mental health provider and his DOC supervisor three times weekly. He has a history of significant chemical dependency and has had several "dirty UA's" since release. The chemical dependency and mental health treatment providers are collaborating to assist him address this serious problem. Mental health and DOC staff are working together to find workshop that would provide him place to work on cars. The RSN bought him some tools to help him work in this trade.
- The third participant continues to be engaged in intensive out patient services because of his mental, physical and chemical dependency issues. He is scheduled to be seen 3x's per both by DOC and mental health. He has had only marginal compliance with attendance and his community corrections officer and case manager have had to check on him almost daily. He initially had difficulty accessing chemical dependency treatment, however he more recently enrolled. He has had several "dirty UA's" for smoking marijuana.

Pierce County RSN: (1 Participant)

- Pierce County had the first DMIO participant to transition into the community. He was released in September 2000 and resides independently He receives coordinated mental health and chemical dependency treatment and is seen daily by his community corrections officer. There has been very close collaboration between DOC and service providers and they have worked jointly to respond to several occurrences of substance abuse. He is enrolled at Pierce College, taking two classes to increase his vocational skills.

Thurston/Mason RSN: (1 Participant)

One participant has been released to transition through this RSN. At present he is receiving in-patient chemical dependency treatment at Pioneer Center North with release planning underway.

Since the inception of the DMIO program, the avenues for treatment have widened with the collaboration and integration of services among the various agencies. Although there are both professional and treatment barriers, agencies are beginning to discuss these issues more openly and search for system solutions. New methods and resources are being explored to engage the program participants as well as the treatment providers. Some agencies are developing innovative ways to provide services and treatment. This is illustrated in the following examples.

- One of our DMIO program participants came to the community with considerable skill in auto repair. The local planning team believed he would make a better community adjustment if he could be involved, at least part time, in automobile engine work. However, his anger management problems create potential instability in his residential situation (living with a roommate with whom he has had problems in the past). The plan generated for this man included locating a shop for him, with rent for the shop covered by DMIO funds, to provide both a place for him to practice his trade and a place to which he can retreat when issues at home result in his need for respite. The DMIO program also was able to purchase tools for his automotive work to assist in his self-employment.

- Another participant is presently an inpatient at Western State Hospital and will likely be there for an extended period of time. The RSN staff and provider are working closely with him and hospital staff to help maintain his stability while an inpatient. The local planning team has authorized supplying him with some pocket money (DMIO funds) for him to use as he chooses (e.g., candy bars, toiletries, personal items) to maximize his coping skills.

As with any project startup, implementation of the DMIO legislation has faced some logistical challenges. These challenges focus around the development of understanding how disparate systems (DOC and community-based mental health treatment) operate, and the varying degree of readiness of these systems statewide to implement the DMIO program strategy.

Examples of logistical issues that have posed challenges during the early phase of implementation are: 1) individuals releasing from prison earlier than expected, resulting in inadequate time for the communities to develop comprehensive transition plans; and 2) communities having difficulties bringing together the local treatment and supports (e.g., housing) and community-based DOC staff, to develop comprehensive plans for these multi-need, high risk people. The statewide review committee and state DMIO program staff have been actively working to monitor the community-based transition process and assisting community providers to resolve these logistical challenges.

Service System Collaboration

The DMIO legislation and program have led to significant relationship building and collaboration between staff from DOC and the DSHS Divisions of Mental Health,

Alcohol and Substance Abuse, and Developmental Disabilities. An overwhelming majority of DMIO program participants have chemical dependency issues in addition to mental health issues.

Prior to the implementation of the DMIO Program, some communities already had alliances that assisted in a seamless provision of services for clients they shared in common. However, in the majority of communities, collaboration at the level required to implement the DMIO program effectively was not in place. New relationships are being developed and new ways of looking at the clients we serve are taking place. Positive collaborative efforts do not appear to fall along any set expectations. For example, challenges have been experienced in both large and small communities, regardless of availability of resources.

Identification of DMIO Offenders

The identification of dangerous mentally ill offenders is well under way, with future refinements being planned to streamline the process. To identify offenders with a mental disorder, the DOC Office of Planning and Research uses existing OBTS (Offender Based Tracking System) database items that have been found to be associated with mental illness to generate a list of offenders for preliminary screening.[5] The list of potential DMIO candidates is further refined through the DMIO program staff procedures discussed earlier in the report.

CDMHPs and Local Mental Health Agencies

As a member of the Statewide Review Committee, the function of the County Designated Mental Health Professional (CDMHP) is to provide expertise regarding the application of the Involuntary Treatment Act (Chapter 71.05 RCW), and assist CDMHPs throughout the state to better appreciate the significance of the CDMHP's role in community safety and the treatment of the DMIO population. At the local level, the CDMHP is available to work closely with the local planning team and consider involuntary detention, under the provisions of Chapter 71.05 RCW, prior to release when requested.

Outcome Study

The Washington Institute for Mental Illness Research and Training (WIMIRT) and the Washington State Institute for Public Policy (WSIPP) are currently conducting an evaluation of SSB 5011, as mandated by the legislature. The evaluation, now in the data collection stage, involves four study components.

[5]See 2000 Washington Institute for Mental Illness Research and Training, "Preliminary Findings: Community Transition Study." Research on mentally ill prisoners released from DOC institutions in 1996-1997.

The comparative study addresses legislative questions on services provided to DMIO program participants, and criminal and psychiatric outcomes. The services provided to and outcomes of DMIO program participants will be compared to mentally ill offenders released from prison prior to the DMIO program. Offenders with similar background characteristics and mental health and criminal history will be selected to compare services and outcomes in order to evaluate program effectiveness.

The descriptive study addresses legislative questions about the quantity and quality of pre- and post-release services that DMIO program participants receive.

The cost-benefit study addresses questions about the impact of SSB 5011, using an economic model to estimate the long-term taxpayer and crime victim costs avoided as a result of any realized DMIO program treatment effects, determined from the results of the comparative study.

The risk tool validation study addresses legislative questions about the validity of the risk assessment tools used to assess dangerousness of DMIO offenders.

The final results of the outcome study are due to the legislature in December 2004. Interim reports will be published on the DMIO selection process and DMIO services (December 2001), the DMIO and comparison group services (December 2002), and on the preliminary recidivism analyses (December 2003).

Future Work/Refinements Needed

The Statewide Multi-system Review Committee has accomplished much during the first year but there is still more to be done. The formal committee policies need additional work, including further refinement of the selection criteria and selection process. Additional committee responsibilities include development of:

- “Best practice" guidelines for community implementation;
- Training methods for sharing "best practice" ideas across the state;
- Conflict resolution process to address local concerns;
- Confidentiality management; and
- Criteria for awarding "exceptional cost" funds.

Finding and establishing appropriate and safe housing for high-risk offenders continues to be a significant hurdle. This includes offenders who are DMIO program participants. The DOC recently established a project position to study and address the housing needs of high-risk offenders. This position is actively researching what programs exist in other states related to housing and housing needs of this population. Additionally, the position is working within Washington State with various agencies (i.e., state, counties, and private sector) to explore options and housing programs.

Appendices

Appendix A - DMIO Implementation Plan Summary

Appendix B - Statewide Multi-System Review Committee Procedures

Appendix C - Additional Information on DMIO Program Participants